FOREIGN SERVICE OF THE PHILIPPINES
CONSULATE GENERAL OF THE REPUBLIC OF THE PHILIPPINES
OSAKA, JAPAN

Twin 21 MID Tower 24F, 2-1-61 Shiromi Chuo-ku, Osaka, Japan
Tel. No. 06-6910-7881 * Fax No. 06-6910-8734
e-mail: consulate@osakapcg.com

FA FORM NO.11
(REVISED 05 MAY 2011)

MEDICAL CERTIFICATE OF VISA APPLICANT

PLEASE TYPE OR PRINT ANSWERS LEGIBLY IN THE SPACES PROVIDED (IF NOT APPLICABLE, WRITE (N/A))

PLACE	DATE	**APPLICANT'S PHOTOGRAPH 5 cm x 5 cm**
CITY	COUNTRY	1. Picture taken within the past 6 months 2. Front View 3. Without eyeglasses 4. Write name on front bottom of photograph

I CERTIFY THAT ON THE ABOVE DATE I EXAMINED

NAME			Staple or paste photo here
AGE	SEX ☐ MALE ☐ FEMALE	CITIZENSHIP	

And that under Philippine Immigration Regulations the applicant should be classified as follows:
(Please encircle the appropriate class)

CLASS A	**DANGEROUS CONTAGIOUS DISEASES** Chancroid, Gonorrhea, Granuloma, Inquinale, Leprosy (Infectious) Lymphogranuloma Venereum, Syphilis (Infectious Stage), Tuberculosis (Active), and AIDS **SERIOUS MENTAL DISORDERS** Mental retardation (mental deficiency) Insanity, previous occurrence of one or more attacks of insanity, antisocial personality, Mental defect, Epilepsy, Sexual deviation, Narcotic drug addiction, Chronic alcoholism.
CLASS B	**IF NOT CLASS A** Person having physical defects, disease or disability serious in degree or permanently in nature that will impair their ability to earn a living as to make them likely to be a public charge
CLASS C	**MINOR CONDITIONS**

MEDICAL RECORDS

1. Pertinent medical history: ____________________
2. Significant physical examination: ____________________
3. Chest X-ray report: (For ages 11 yrs. and above): ____________________
   - Present X-ray film (14 x 17 inches): ____________________
4. Laboratory Examination : (Attach laboratory reports): ____________________
   - A: Blood serolory: (Ages 15 years and above): ____________________
   - B: Urine: (Ages 1 year and above): ____________________
   - C: Stool: (Ages 1 year and above): ____________________
   - D: Other examination(s) if necessary: ____________________

Examining Physician (Print Full Name) ____________________

Name & Address of Clinic or Hospital ____________________

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Signature of Examining Physician

NOTE: PLEASE PREPARE SEPARATE AIDS TEST REPORT